Michigan Department of Community Health

NURSING FACILITY ELIGIBILITY AND ADMISSION PROCESS

The following changes replace current policy published in Section 4 of the Nursing Facilities Coverages and Limitations Chapter.

SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

4.1 Nursing Facility Eligibility

There are five necessary components for determining eligibility for Medicaid nursing facility reimbursement.

4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility by the Family Independence Agency (FIA). When a Medicaid-eligible or potentially eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565-C) to the local FIA office to establish/confirm eligibility for Medicaid benefits. (Refer to the Forms Appendix of the Medicaid Provider Manual for a sample form.)

A facility is considered to be officially notified of a beneficiary's Medicaid eligibility when they have received the completed MSA-2565-C, Facility Admissions Notice.

In order for Medicaid to reimburse nursing facility services, the beneficiary must be in a Medicaid-certified bed.

4.1.B. Correct/Timely Pre-admission Screening/Annual Resident Review (PASARR)

The Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Pre-admission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form (DCH-3877) may be found at the MDCH web site. (Refer to the Directory Appendix of the Medicaid Provider Manual.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the Level I screening was performed and that the Level II screening was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

4.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

4.1.D. Appropriate Placement Based on Medicaid Nursing Facility Level of Care Determination

4.1.D.1 Michigan Medicaid Nursing Facility Level of Care Determination

The nursing facility must verify beneficiary appropriateness for nursing facility services by completing an electronic web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination form that can be found at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care." The nursing facility may not bill Medicaid for services provided when the beneficiary does not meet the established criteria identified through the Michigan Medicaid Nursing Facility Level of Care Determination or Nursing Facility Level of Care Exception Process, and may not bill the beneficiary unless the beneficiary has been advised of the denial and elects, in advance, to pay privately for services.

Services will not be reimbursed when the determination does not demonstrate functional/medical eligibility through the electronic web-based tool. In addition, providers must submit the information via the web no later than 7 calendar days following start of service.

A copy of the Michigan Medicaid Nursing Facility Level of Care Determination form and the Field Definition Guidelines are on the MDCH website at www.michigan.gov/mdch, select "Providers," select "Information for Medicaid Providers," " Michigan Medicaid Nursing Facility Level of Care Determination."

The Michigan Medicaid Nursing Facility Level of Care Determination must be used by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker, or physician assistant) representing the proposed provider. Nonclinical staff may perform the evaluation when clinical oversight by a professional is performed. The nursing facility will be held responsible for billing Medicaid for only those residents who meet the criteria outlined in this bulletin.

For residents currently in the facility on the implementation date, the Michigan Medicaid Nursing Facility Level of Care Determination must be applied no later than the annual date of the next annual MDS assessment.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the electronic web-based tool for:

- **all new admissions of Medicaid-eligible beneficiaries**, regardless of primary payer source, if Medicaid reimbursement beyond Medicare co-insurance and deductible amounts will be requested

- **non-emergency transfers of Medicaid-eligible beneficiaries to** another nursing facility, including transfers originating from a nursing facility that is undergoing a voluntary facility closure

- **disenrollment of a beneficiary from a Medicaid Health Plan** which has been paying for nursing facility services

- **private-pay residents already residing in a nursing facility** who are applying for Medicaid as the payer for nursing facility services

- **dually eligible** beneficiaries who wish to return to their Medicaid nursing facility bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.

Completion of the Michigan Medicaid Nursing Facility Level of Care Determination is not required in the following situations:

- **any transfer of a Medicaid-eligible beneficiary from a nursing facility that is undergoing an involuntary facility closure due to Federal or State regulatory enforcement action**; situations for retrospective review of transferred residents will still apply

- **emergency transfer of a Medicaid-eligible beneficiary** from a nursing facility experiencing a hazardous condition (i.e., fire, flood, loss of heat) that could cause harm to residents when such transfers have been approved by the State Survey Agency

- **hospice beneficiaries who are being admitted** to the nursing facility for any services

- nursing facility readmissions when the resident level of care code determined by FIA has not changed, as long as the beneficiary was determined eligible previously.

Process Guidelines define required process steps for use of the electronic web-based tool and application of the criteria, informed choice, and specific discharge planning requirements. The Process Guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," select "Information for Medicaid Providers," select "Michigan Medicaid Nursing Facility Level of Care Determination."

The revised functional/medical criteria include seven domains of need:

  - Activities of Daily Living,
  - Cognitive Performance,
  - Physician Involvement,
  - Treatments and Conditions,
  - Skilled Rehabilitation Therapies,
  - Behavior, and
  - Service Dependency.

For residents who qualify under only three of these domains (Physician Involvement, Treatments and Conditions, and Skilled Rehabilitation Therapies), specific restorative nursing plans and assertive discharge planning must be evident and documented within the medical record. These requirements are specified in the Process Guidelines.

The electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination must be completed only once for each admission for an individual provider.

4.1.D.2 Nursing Facility Level of Care Exception Process (NF LOC Exception Process)

An exception process is available for those applicants who have demonstrated a significant level of long term care need but do not meet the Michigan Medicaid Nursing Facility Level of Care criteria. The NF LOC Exception Process is initiated when the prospective provider telephones MDCH or its designee and requests review after the applicant has been determined ineligible using the electronic web-based tool. The NF LOC Exception Criteria is available on the MDCH website at

www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination." To request an NF LOC Exception review, providers may contact MDCH or its designee. Contact information is available at the above MDCH website.

4.1.D.3 Telephone Intake Guidelines

The Telephone Intake Guidelines are a list of questions that identify potential nursing facility residents. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the nursing facility. A copy of the guidelines is attached (see Attachment E). This document is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.1.D.4 Annual Re-certification

Nursing facility residents must undergo annual re-certification to establish that they continue to meet functional/medical eligibility requirements; however, Medicaid (as defined by federal regulation) residents must also meet the nursing facility level of care definition on an ongoing basis for services to be reimbursed. Quarterly Minimum Data Set (MDS) assessments and progress notes must demonstrate that the resident has met the criteria on an ongoing basis. MDCH suggests that the annual re-certification review coincide with the Annual Resident Review required under the Michigan PASARR policy.

All current nursing facility residents must be assessed using the electronic web-based Michigan Medicaid Nursing Facility Level of Care Determination at the time of the next MDS annual assessment. Residents who have resided in a facility for 12 months or longer must be offered the opportunity and assistance to transition to the community, but may not be required to do so. If the nursing facility determines that the resident who has been in the facility for less than 12 months is not eligible for services based on functional/medical criteria, the resident must be provided an adverse action notice and referred to appropriate service programs.

4.1.D.5 Retrospective Review and Medicaid Recovery

At random and whenever indicated, MDCH or its designee will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination and the quality of Medicaid MDS data overall. If the resident is found to be ineligible for nursing facility services, MDCH will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

4.1.D.6 Adverse Action Notice

When the provider determines that the applicant or current resident does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the provider must immediately issue an adverse action notice to the applicant or their authorized representative. The provider must also offer the applicant referral information about services that may help meet their needs. The action notice must include all of the language of the sample letters for long term care. You may find these letters at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

As with any benefit denial, the beneficiary may request an administrative hearing. The Administrative Tribunal Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information for the Administrative Tribunal.)

Immediate Review-Adverse Action Notices

MDCH or its designee will review all pre-admission or continued stay adverse action notices upon request by a Medicaid beneficiary or their representative. When a beneficiary requests an immediate review before noon of the first working day after the date of receipt of the notice:

- MDCH or its designee will request that the nursing facility provide pertinent information by close of business of the first working day after the date the beneficiary (or representative) requests an immediate review.

- MDCH or its designee will review the records, obtain information from the beneficiary (or beneficiary representative) and notify the beneficiary and the provider of the determination by the first full working day after the date of receipt of the beneficiary request and the required medical records.

- The beneficiary (or authorized representative) may still request an MDCH appeal of the Level of Care Determination.

Beneficiaries may call the MDCH designee to request an immediate review. Contact information can be found at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.1.E Freedom of Choice

When an applicant has qualified for services under the nursing facility level of care criteria, they must be informed of their benefit options and elect, in writing, to receive services in a specific program. This election must take place prior to initiating nursing facility services under Medicaid.

The applicant, or legal representative, must be informed of the following:

- services available under the nursing facility program.

- services available in a community setting, including those available through the MI Choice Program or PACE program.

If applicants are interested in community-based care, the nursing facility must provide appropriate referral information as identified in the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. The guidelines are available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination." Applicants who prefer a community long-term care option, but are admitted to a nursing facility because of unavailable slots or other considerations, must also have an active discharge plan documented for at least the first year of care.

Applicants must indicate their choice of program in writing by signing the Freedom of Choice form. A completed copy of this form must be retained for a period of three years. The completed form must be kept in the medical record if the resident chooses admission to a nursing facility. The Freedom of Choice form must also be witnessed by an applicant representative when available.

A copy of this form is included with the Michigan Medicaid Nursing Facility Level of Care Determination. This document is available on the MDCH website at www.michigan.gov/mdch, select "Providers," "Information for Medicaid Providers," "Michigan Medicaid Nursing Facility Level of Care Determination."

4.2 Appeals

4.2.A. Individual Appeals

Financial Eligibility: A determination that an applicant is not eligible for Medicaid is an adverse action. Applicants may appeal such an action to the Family Independence Agency (FIA).

Functional/Medical Eligibility: A determination that an applicant is not **functionally/medically eligible for nursing facility services** is an adverse action. If the applicant and/or representative disagree with the determination, he has the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for MDCH website information.)

4.2.B. Provider Appeals

A retrospective determination that an applicant is not eligible for nursing facility services based on review of the functional/medical screening is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this determination, an appeal may be filed with MDCH. Information regarding the MDCH appeal process may be found at the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual.)

4.3 Admission Requirements

Prior to or upon admission, the nursing facility must provide residents and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with an asterisk (*****).

- Rights as defined by federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *****
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid “Know Your Rights” booklet; *****
- Non-covered items and services, as well as the costs, for which the beneficiary may be charged (admission to the facility cannot be denied because the beneficiary is unable to pay in advance for non-covered services); *****
- Facility policies regarding protection and maintenance of personal funds; *****
- A description of the facility policies to implement advanced directives; *****
- Facility policies regarding the availability of hospice care; *****
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; ***** and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

4.4 Preadmission Contracts

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).